U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 April 2007

Case No. 2005-BLA-6281

In the Matter of:
M.D.A.,[1]
Claimant,

v.

CENTRAL OHIO COAL, c/o
GENERAL RECOVEY, INC.,
Employer,
and
CONSOL ENERGY, INC., c/o
ACORDIA EMPLOYERS SERVICE,
Carrier,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Thomas E. Johnson, Esq.
On behalf of Claimant

William S. Mattingley, Esq.
On behalf of Employer

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On September 12, 2005, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 31).[3] A formal hearing on this matter was conducted on November 17, 2006, in Zanesville, Ohio by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

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withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the transcript.

[4] At the hearing, the parties stipulated to at least 32 years of coal mine employment. (Tr. 11). Additionally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (DX 31, Item 18).

3. Whether the Miner is totally disabled; and

4. Whether the Miner's disability is due to pneumoconiosis;

(DX 31).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

M.D.A. ("Claimant") was born on January 19, 1940, and was 66 years old at the time of the hearing. (DX 2; Tr. 13). He completed the tenth grade. (DX 2). On February 24, 1961, Claimant married M.A.G., and they remain married. (DX 2, 7; Tr. 14). He has no dependent children. (DX 2; Tr. 14). Employer concedes, and I so find, that Claimant has one dependent for purposes of augmentation. (DX 31).

On his application for benefits, Claimant stated that he engaged in coal mine employment for at least 34 years. (DX 2). Claimant's last coal mine employment was as a welder and a repairman in a strip mine. (DX 3; Tr. 18-30). Claimant described the physical requirements of the work to include lifting and carrying as much as 100 pounds, swinging a twelve-pound sledge hammer, and using a twenty-pound pry bar. (Tr. 30-33). Claimant stated that he retired from coal mining in 2001. (DX 2; Tr. 14). He also noted on his application that he has not previously filed a federal pneumoconiosis disability claim. (DX 2).

Claimant testified that no doctor has ever said that he has asthma. (Tr. 35). However, he stated that Dr. Kalis, his family physician, prescribed asthma medication in 2005. (Tr. 35-36).

Procedural History

Claimant filed a claim for benefits under the Act on August 23, 2004. (DX 2). On July 22, 2005, the District Director, Office of Workers' Compensation, issued a proposed decision and order – award of benefits and responsible operator. (DX 27). On August 2, 2005, Employer requested a formal hearing. (DX 28). On September 12, 2005, this matter was transferred to the Office of Administrative Law Judges. (DX 31).

Length of Coal Mine Employment

On his application, Claimant stated that he engaged in coal mine employment for at least 34 years. (DX 2). The Director determined that Claimant has at least 32 years of coal mine employment. (DX 27). The parties stipulated that Claimant worked at least 32 years in or

around one or more coal mines. (Tr. 11). I find that the record supports this stipulation, (DX 3-5), and therefore, I hold that the Claimant worked at least 32 years in or around one or more coal mines.

Claimant's last employment was in the State of Ohio (DX 3); therefore, the law of the Sixth Circuit is controlling.[5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Central Ohio Coal as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 16, Tr. 18). Employer does not contest its designation as responsible operator. (DX 31). Therefore, I find that Central Ohio Coal is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Paul Knight to provide his Department of Labor sponsored complete pulmonary examination. (DX 8). The examination was conducted on September 28, 2004 and the x-ray was interpreted by Dr. Muchnok with a subsequent x-ray and interpretation

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

on November 16, 2004.[6] I admit the DOL sponsored evaluations under § 725.406(b). I also admit Dr. Gaziano's quality-only interpretations of the x-ray under § 725.406(c).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 3). In addition to the DOL sponsored examination, Claimant designated Dr. Cohen's interpretation of the April 2005 x-ray and his April 2005 PFT and ABG studies. He also designated Dr. Cohen's June 9, 2005 and Dr. Diaz's October 19, 2006 medical reports as initial evidence, and Dr. Knight's October 22, 2006 letter as rehabilitative evidence. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the above designated evidence.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (CX 6). Employer designated Dr. Rosenberg's May 11, 2005 complete pulmonary examination, Dr. Spagnolo's August 27, 2006 medical report, and Dr. Meyer's rebuttal interpretation of the April 16, 2005 x-ray. Employer also designated supporting depositions by Drs. Knight, Cohen, and Rosenberg. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the above designated evidence. Finally, Dr. Rosenberg's deposition also includes an interpretation of the April 26, 2005 x-ray. Since this report is admissible as either a second initial report or as a rebuttal report, Dr. Rosenberg's consideration of this evidence is permitted, and the x-ray interpretation will be considered in this adjudication.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 8	09/28/04	10/02/04	Muchnok, BCR[7],B-reader[8]	Negative[9]
DX 8	09/28/04	10/25/04	Gaziano. B-reader	Unreadable
DX 12	11/16/04	11/25/04	Muchnok, BCR, B-reader	Negative
DX 13	11/16/04	12/08/04	Gaziano. B-reader	Quality only

[6] Due to Dr. Gaziano's October 25, 2004 determination that the September 28, 2004 x-ray was unreadable, the DOL requested that Dr. Muchnok conduct and interpret a second x-ray reading. I note that Dr. Muchnok, who is dually certified as a radiologist and B-reader, found that the September 2004 film was readable. I further note that Dr. Gaziano is only a B-reader. Therefore, since Dr. Muchnok is a more highly credentialed x-ray interpreter, and since he found the film to be readable, I find that the initial study was of acceptable quality and that the subsequent study was unnecessary. However, since Dr. Muchnok reached the same conclusions regarding both films, and since the parties have stipulated that Claimant does not have clinical pneumoconiosis (Tr. 12), I find that there is no harm in allowing both of Drs. Muchnok and Gaziano's reports to be admitted and considered in this adjudication.

[7] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[8] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[9] While Dr. Muchnok found this film to be underexposed, he still rated it quality 2. (DX 8).

DX 9	11/16/04	04/16/05	Meyer, BCR, B-reader	Negative
EX 2	04/26/05	05/17/05	Cohen, B-reader	0/1 pq
EX 5	04/26/05	11/12/06	Rosenberg, B-reader	Negative
DX 10	05/11/05	05/11/05	Rosenberg, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[10]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 8 9/28/04	Good/ Good/ Yes	64 66.5"	1.98 1.98*	3.54 3.63*	87 92*	56 **54***	No No*
DX 11 4/27/05	Good/ Good/ Yes	65 65"	1.71 1.76*	3.96 4.00*	**43** **44***	--- ---	No No*
DX 10 5/11/05	Good/ Good/ Yes	65 65"	1.75 1.73*	3.22 3.42*	**64** 71*	**54** **5**0*	No No*

*indicates post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 8	10/1/04	42.1 44.3*	67.8 75.6*	No No*
DX 11	4/27/05	39	77.2	No
DX 10	5/11/05	28.6 31.2*	67.2 75.4*	No No*

* indicates post-exercise values

Narrative Reports

Dr. Paul Knight, an internist (DX 10), examined Claimant on September 28, 2004 and submitted a report dated November 30, 2004. (DX 8). Dr. Knight considered the following: symptomatology (sputum, wheezing, dyspnea, cough, and orthopnea), employment history (32 years coal mine employment), individual history (pneumonia, attacks of wheezing, chronic bronchitis, bronchial asthma, allergies, and high blood pressure), family history (high blood pressure, cancer, and allergies), smoking history (1 ½ to 2 packs per day, beginning in his teens

[10] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). Dr. Knight testified that it is typical for his office to measure height wearing shoes. (DX 10). Therefore, giving more weight to the findings by the other physicians of record, I find Claimant's height to be 65 inches.

and ending at age 35), physical examination (lungs were hyperresonant on percussion, and there were decreased breath sounds and decreased air movement, but no wheezing on auscultation), chest x-ray (clear with no apparent abnormality), PFT (forced vital capacity is within normal limits, there is a moderate obstructive ventilatory defect present, there is no significant change in volume or flow after bronchodilators), ABG, and an EKG scan (sinus bradycardia). Dr. Knight diagnosed asthmatic bronchitis caused by a combination of prior smoking history and significant dust exposure in the course of his coal mine employment. Based on the PFT, he opined that Claimant's degree of impairment would prevent him from performing his previous coal-mining work or any dusty or dirty type employment.

Dr. Knight submitted a supplemental report dated January 15, 2005, which was attached to his September 2004 report. (DX 8). Dr. Knight stated that Claimant has a lung disease caused co-equally by his prior exposure to coal dust and tobacco. Due to the resulting moderate pulmonary impairment, diagnosed, in part, by the PFT, Dr. Knight opined that Claimant does not have the respiratory capacity to perform his last work as a coal miner or perform comparable work.

Dr. Knight was deposed by the Employer on May 24, 2005, when he repeated the findings of his earlier written report. (DX 10). Dr. Knight added that he was concerned with the fact that while Claimant had a smoking history of 30 to 40 pack-years, he had quit a long time ago but his respiratory symptoms seemed to get worse. However, he admitted that he did not have enough information to determine the precise etiology or cause of Claimant's dyspnea or asthmatic bronchitis without further testing. He also conceded that Claimant's weight could contribute to his sensations of breathlessness. Dr. Knight stated that since Claimant was on a long-term bronchodilator for his lung treatment, it was not surprising he did not have any response to the bronchodilator. Dr. Knight opined that Claimant retains the pulmonary capacity to lift and carry something in the neighborhood of 15 pounds for 20 feet, but due to the obstruction, repetition of this task would be difficult. Based on the fact that a fair amount of time had transpired between Claimant's smoking and when his symptoms became more severe, and considering the fact that Claimant's exposure to coal dust continued during this period, Dr. Knight concluded that coal dust exposure and tobacco smoking were co-equal in causing his pulmonary condition. However, he admitted that he always finds it difficult, when there are multiple exposures, to determine which is which. As a result, he said that he often ends up saying that they are co-equal etiologies. He also added that this condition could be caused, in part, by Claimant's idiopathic chronic asthma. Dr. Knight concluded that while Claimant is totally disabled from performing his last coal mining job, he is less certain whether Claimant has multiple causes for this impairment, or just one.

Dr. Knight submitted a supplemental report dated October 22, 2006. (CX 2). In addition to his previous report and deposition, Dr. Knight reviewed Dr. Cohen's June 9, 2005 medical report. Dr. Knight stated that Dr. Cohen's PFT was more complete than his own, and based on these results, he opined that Claimant had a moderate obstruction. Furthermore, he diagnosed legal pneumoconiosis, opining that Claimant's 30 years of coal mining clearly contributed to his current respiratory disability. Finally, based on the testing and examination, Dr. Knight stated that Claimant could not be expected to perform any type of coal related work or any type of work in a dusty or dirty occupation.

Dr. Andrew Cohen, an internist, pulmonologist, and B-reader, examined Claimant on April 26, 2005, and submitted a report dated June 9, 2005. (DX 11). Dr. Cohen considered the following: the DOL sponsored complete pulmonary evaluation, symptomatology (shortness of breath unaffected by Albuterol inhalers, wheezing, coughing, and clear phlegm production), employment history (32 years coal mine employment, last working as a welder in the shop performing very strenuous tasks), individual history (hypertension, hyperthyroid, acid reflux, hypercholesteremia, and benign prostatic hypertrophy), smoking history (16 years at a rate of 1 ½ packs per day and 2 years at 2 packs per day, for a total of 28 pack years), physical examination (clear to auscultation bilaterally), chest x-ray (0/1), PFT (moderately severe obstructive defect with no clear response to bronchodilators), and an ABG (normal for patient's age). While Dr. Cohen noted a 28 pack-year smoking history, he diagnosed CWP based on coal dust exposure, symptoms, the PFT, a borderline negative x-ray, and the fact that there is no history of any other occupational exposure which would cause obstructive lung disease. He also acknowledged that Claimant's exposure to welding fumes may have had some significant effect on his respiratory symptoms and chronic bronchitis, but he opined that it is more likely than not that the impact of these fumes was comparatively small. He opined that the impairment from Claimant's moderate obstructive lunge disease is severe enough to preclude him from engaging in the heavy physical exertion required of his last coal mining job repairing heavy mine equipment where he was required to lift objects weighing up to 100 pounds.

Dr. Cohen was deposed by the Employer on September 7, 2005, when he repeated the findings of his earlier written report. (EX 1). In addition to the medical evidence he considered in conjunction with his prior report, Dr. Cohen also considered Dr. Rosenberg's report and Dr. Knight's deposition transcript. Dr. Cohen again opined that Claimant has at least a moderate degree of obstructive lung disease and no restrictive lung disease. Also, his PFT showed no reversibility post-bronchodilator, which, in conjunction with a medical history that fails to mention asthma, effectively rules out the condition. Dr. Cohen explained that while Claimant's smoking history was significant, it was not huge, but that he was not able to specifically apportion the amount of impairment that was caused by smoking or coal dust exposure because there is no test that can quantify the difference between the toxins. He also reiterated that welding fume exposure may have contributed to Claimant's impairment. He criticized Dr. Rosenberg's post-exercise ABG study by stating that Claimant performed basically no exercise so the study was inconclusive.

Dr. David Rosenberg, an internist, pulmonologist, and B-reader, examined Claimant on May 11, 2005 and submitted a report dated May 20, 2005. (DX 10). Dr. Rosenberg considered the following: the DOL sponsored evaluation, symptomatology (cough, sputum, wheeze, shortness of breath, and chest pressure), employment history (32 years coal mine employment, last working as a welder and other assorted jobs, and ending in 2001), individual history (previously hospitalized for breathing problems), family history (carcinoma, myocardial infarction), smoking history (1 ¼ to 1 ½ packs per day for 18 years), physical examination (decreased breath sounds without rales, rhonchi or wheezes), chest x-ray (0/0), PFT (moderate airflow obstruction without a bronchodilator response and no restriction), ABG (normal exercise response), and an EKG (normal). Dr. Rosenberg diagnosed mild to moderate airflow obstruction, without restriction, accompanied by a normal diffusing capacity measurement. He opined that while Claimant does have a significant respiratory impairment, his test results were

above the disability standard, and therefore, he is not disabled from performing his previous coal mining job or similarly arduous types of employment. Dr. Rosenberg further explained that while airflow obstruction can be the result of coal dust exposure, the pattern of obstruction identified in Claimant does not fit the pattern of obstruction seen with coal dust exposure. Specifically, he noted that Claimant's FVC increased 200cc after bronchodilator, which he explained was not to be expected in relation to the fixed impairments associated with CWP. Dr. Rosenberg concluded that Claimant's pattern of obstruction is classic for smoking-related COPD.

Dr. Rosenberg was deposed by the Employer on November 14, 2006, when he repeated the findings of his earlier written report. (EX 5). Dr. Rosenberg stated that the post bronchodilator study probably does not meet the criteria level for significance, but that 200 ccs borders on significance. He also stated that he intentionally failed to perform a maximal stress test as part of the ABG because Claimant was an older gentleman, which leads to a lot of risk factors, and he basically was concerned with obtaining a steady rate to determine whether there was an improvement with exercise. In addition to the evidence he considered in conjunction with his previous report, Dr. Rosenberg also reviewed Dr. Cohen's examination report. He noted that Dr. Cohen's PFT study conducted one month earlier showed a significantly increased FVC measurement, and he opined that this variable lung function over a short period of time shows that the pulmonary impairment is not fixed in nature. He further stated that the variability seen across all the FVC measures of record is not consistent with what one would associate with coal mine dust related airways disease, but instead, is more likely the result of a hyperactive airways component or an asthmatic component. Dr. Rosenberg criticized Dr. Cohen's conclusions, noting that Dr. Cohen basically coupled 32 years coal dust exposure with respiratory symptoms of airways disease, and equated this to legal CWP. Dr. Rosenberg explained that you cannot simply say that an individual worked in coal mines and has a disease, so the condition must have been caused by mining. Instead, he explained, a physician must look at the objective criteria, and in this case, the test results are not consistent with coal dust induced obstruction, but are not atypical with cigarette smoke induced airways obstruction. Turning to total disability, Dr. Rosenberg stated that based on the FEV 1 value of 68%, Claimant would be considered to have a mild to moderate impairment, and thus, could perform medium to intermittently heavy-type work from a ventilatory perspective.

Dr. Samuel Spagnolo, an internist and pulmonologist, submitted a medical evidence review on August 27, 2006 in which he considered all of the previously submitted medical evidence of record. (EX 3-4). Dr. Spagnolo stated that there was no radiographic evidence of pneumoconiosis, but that the spirometry values suggest the presence of a moderate airway obstruction but no restrictive pulmonary impairment. He also noted that there was no evidence of emphysema, but that the lung function values were most compatible with Claimant's prior medical history of bronchial asthma. Dr. Spagnolo explained that there were multiple possibilities for a lack of bronchodilator response, including the fact that Claimant was taking a long-acting bronchodilator agent, the fact that he smoked for many years resulting in a fixed pulmonary obstruction, or the fact that his exposure to welding fumes likely contributed to and worsened his asthmatic condition. Dr. Spagnolo concluded that based on the laboratory and clinical findings, that there is insufficient evidence to justify a diagnosis of CWP, and that Claimant retains the pulmonary capacity to perform his usual coal mine employment.

Dr. Philip Diaz, an associate professor of medicine, performed a medical records review and submitted a report on October 19, 2006 in which he considered DX 1-31 and EX 1-4. (CX 1). Dr. Diaz opined that Claimant has clinical and physiological evidence of COPD, and that coal dust exposure contributed significantly to this condition. Noting Claimant's 28 pack-year smoking history that ended in 1976, and the fact that he continued to work in and around coal dust until 2001, Dr. Diaz opined that Claimant continued to show a progressive decline in functional status and worsening respiratory symptoms between 1976 and 2001. He also explained that Claimant's substantial airflow obstruction is disproportionate to the 28 pack-year smoking history alone. Dr. Diaz concluded that the obstructive lung disease renders Claimant unable to perform the heavy manual labor required by his last job as a welder.

Smoking History

Claimant testified that he smoked from 1958 until 1973 at a rate of 1 ½ packs per day, and from 1974 until 1976 at a rate of 2 packs per day, for a total of 26 ½ pack years. (Tr. 34-35). Dr. Knight reported a 1 ½ to 2 packs per day smoking history beginning in his teens and ending at age 35. (DX 8). Dr. Rosenberg reported 1 ¼ to 1 ½ packs per day for 18 years. (DX 10). Finally, Dr. Cohen reported smoking for 16 years at a rate of 1 ½ packs per day and 2 years at 2 packs per day. (DX 11). I find that the amounts Claimant reported to the physicians is generally consistent with his testimony. Therefore, I find that Claimant has a 26 ½ pack-year smoking history, but that he quit smoking approximately 30 years ago.

DISCUSSION AND APPLICABLE LAW

This claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications.

See McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989). In *Roberts v. Bethlehem Mines Corp*., 8 B.L.R. 1-211, 1-213 n. 5 (1985), however, the Board stated that it "takes official notice that the qualifications of a certified radiologist are at least comparable if not superior to a physician certified as a reader pursuant to 42 C.F.R. §37.51 …." Finally, if the film quality is "poor" or "unreadable," then the study may be given little weight. *Gober v. Reading Anthracite Co.,* 12 B.L.R. 1-67 (1988).

The record contains six interpretations of four chest x-rays, and two quality-only interpretations. Dr. Muchnok, a radiologist and B-reader, interpreted the September 28, 2004 x-ray as negative for pneumoconiosis. There were no positive readings. Therefore, I find this film to be negative.

Drs. Muchnok and Meyer, both dually certified, read the November 16, 2004 film as negative. There were no positive readings. Therefore, I find this film to be negative.

Drs. Cohen and Rosenberg, both B-readers, interpreted the April 26, 2005 x-ray to be negative. There were no positive readings. Therefore, I find this film to be negative.

Dr. Rosenberg read the May 5, 2005 film as negative for pneumoconiosis. There were no positive readings. Therefore, I find this film to be negative.

I have determined that all four x-rays of record are unanimously negative for pneumoconiosis. Therefore, I find that Claimant has not established the presence of pneumoconiosis by a preponderance of the evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has not established the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary

> function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,*. 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

Dr. Knight, an internist, and Dr. Cohen, an internist and pulmonologist, considered PFT and ABG studies, accurate smoking and coal mine employment histories, and physical examinations. Dr. Diaz, an associate professor of medicine, performed an extensive medical evidence review. These three physicians all determined that Claimant's COPD was the combined result of both his previous smoking habit and his many years of exposure to coal dust. I find that the objective evidence they considered adequately supports their opinions. Therefore, bolstered by their advanced credentials, I find that their opinions are well-reasoned and well-documented, and accord them probative weight.

Dr. Rosenberg, an internist and pulmonologist, similarly considered accurate employment history, smoking history, PFT and ABG studies, and a physical examination. Dr. Spagnolo, an internist and pulmonologist, performed an extensive medical evidence review. They both concluded that Claimant does not suffer from pneumoconiosis. I find that the objective evidence they considered adequately supports their opinions. Therefore, bolstered by their advanced credentials, I find that their opinions are well-reasoned and well-documented, and accord them probative weight.

The evidentiary record contains five reasoned narrative medical opinions. Three finding that Claimant suffers from legal pneumoconiosis, and two concluding that his obstruction is the result of cigarette smoking or other pulmonary conditions. This task of determining etiology is not made any easier by the fact that the physicians of record agree on almost nothing. Dr. Knight identified a history of bronchial asthma and diagnosed asthma caused in part by coal dust exposure. Drs. Rosenberg and Spagnolo concluded that Claimant's condition is consistent with bronchial asthma, but provided no explanation as to why this condition could not have been caused or exacerbated by coal dust exposure. Dr. Cohen, on the other hand, concluded that Claimant does not have asthma because there is no history of the condition and there was no post-bronchodilator reversibility.

Similarly, the physicians disagree as to the reasons why there was no post-bronchodilator reversibility. Dr. Knight and Dr. Spagnolo conclude that this could be the result of long-acting bronchodilator agents used for the treatment of his pulmonary condition. Dr. Cohen cites the lack of reversibility as proof that Claimant does not have asthma, but fails to explain why such a condition excluded clinical and legal pneumoconiosis. Finally, while Dr. Rosenberg identifies a reversible post-bronchodilator component, he concedes that this improvement is not legally significant. Yet, he goes on to use this insignificant response as proof that Claimant does not have a fixed pulmonary condition, and thus, that his impairment cannot be from coal dust exposure.

Many of the physicians of record also attempted to consider the impact of exposure to welding fumes or Claimant's weight as possible contributors to Claimant's pulmonary condition or the symptoms he reported. I note, however, that none of these experts definitively stated that either of these conditions were solely responsible for the level of impairment observed in this miner. Therefore, I find that neither weight nor exposure to welding fumes is a significant contributor to the testing results or Claimant's impairment.

Dr. Rosenberg equivocally concluded his deposition by stating that the test results are not consistent with coal dust induced obstruction, but are not atypical with cigarette smoke induced airways obstruction. This lack of certainty is a consistent theme across most of the reports. For example, Dr. Knight found coal dust and cigarette smoking to be co-equal contributors because when there are multiple exposures, it is difficult to determine which is which. Likewise, Dr. Cohen admitted that there are no tests that can quantify the difference between the toxins.

Despite this lack of a definitive cause, I find that the record includes certain undisputed factors that assist the undersigned in determining the nature of Claimant's pulmonary condition. First, while Claimant may or may not have bronchial asthma, no physician of record disputed Dr. Knight's conclusion that if such a condition exists, it was caused, in part, by coal dust exposure. Second, whether or not Claimant's pulmonary condition is reversible, the fact remains that every physician found him to suffer from a pulmonary impairment even after bronchodilators were administered. This leads the undersigned to conclude by a preponderance of the evidence that there exists in this gentleman an underlying, fixed impairment consistent with legal pneumoconiosis. Third, even though Claimant has a significant smoking history, as noted by Drs. Diaz and Knight, the truth remains that his exposure to coal dust continued for 25 years after he quit smoking, and yet his pulmonary condition continued to decline over that period. This leads the undersigned to agree with the opinions that Claimant's condition is more than just the result of his distant smoking habit. Finally, Drs. Diaz and Knight both opined that Claimant's pulmonary condition is more severe than that which would be caused by a 28 pack-year smoking history alone, and thus, his obstruction must be caused, in part, by the inhalation of coal dust.

Considering these factors, I am inclined to accord more weight to the reasoned and documented opinions of Drs. Diaz, Cohen, and Knight than the divergent opinions by Drs. Rosenberg and Spagnolo. Thus, I find that the opinions by Drs. Diaz, Cohen, and Knight are better supported by the objective evidence. Therefore, I find that Claimant has proven the existence of legal pneumoconiosis by a preponderance of the evidence under subsection (a)(4).

Claimant has not established the presence of pneumoconiosis under subsection (a)(1)-(3). However, he has successfully proven that his obstructive pulmonary impairment was cause, in part, by legal pneumoconiosis. Therefore, upon consideration of all the evidence under §718.202 (a), I find that Claimant has proven the existence of pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established 32 years of coal mine employment, and as no rebuttal evidence was presented, I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the presumption set forth in § 718.203(b).[11]

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. There are no PFT values equal to or below those found in Appendix B of Part 718. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718.

[11] By use of a three-page, single space, block quote citing Tenth Circuit precedent, Employer argues that the rebuttable presumption of § 718.203(a) is not applicable in the case of legal pneumoconiosis. As I have found that the opinions of Drs. Knight, Cohen, and Diaz are more convincing than those by Drs. Rosenberg and Spagnolo, and as these physicians all concluded that Claimant's pneumoconiosis arose, in part, from coal dust exposure, I now find that the preponderance of the evidence supports a finding that Claimant's exposure to coal dust was the result of his 32 years of coal mine employment. In addition, while several of the physicians of record noted Claimant's exposure to welding fumes, none stated that this exposure was a primary cause of Claimant's impairment. Therefore, even without the presumption of § 718.203(a), I find that the evidence supports a finding that Claimant's legal pneumoconiosis arose from his coal mine employment.

None of the ABG evidence of record produced values that meet the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has not established the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment.

In assessing total disability, the administrative law judge is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Claimant's usual coal mine employment as a welder and repairman involved lifting and carrying as much as 100 pounds, swinging a twelve-pound sledge hammer, and using a twenty-pound pry bar. (Tr. 30-33).

Drs. Rosenberg and Spagnolo both opined that since the PFT and ABG results were non-qualifying under DOL standards, Claimant was not totally disabled from a pulmonary standpoint. The objective evidence they cited as a basis for their opinions supports their conclusions, and thus, I find their conclusions to be well-reasoned and well-documented. However, I also find their opinions to be little more than a reiteration of my findings under § 718.204(b)(2)(i-ii).

Dr. Knight opined that Claimant was totally disabled from performing his previous coal-mining work or any dusty or dirty type employment. However, the analysis under this subsection is whether Claimant has the pulmonary capacity to perform the exertional requirements of his last coal mining position, not whether he can continue to work in a dusty or a dirty environment. Therefore, while it is clear that Dr. Knight equally understood the heavy physical requirements of Claimant's last job in the mines, it is apparent that he did not focus his opinion on these demands. Therefore, I accord his opinion little weight.

Drs. Cohen and Diaz recognized the heavy exertional requirements of Claimant's last job, and considered them in conjunction with the PFT results to conclude that Claimant was totally disabled from performing this work. As their opinions are based on the objective data of record and take into consideration the specifics of Claimant's last coal mining work, I find their conclusions to be well-reasoned and well-documented. Therefore, bolstered by their credentials, I accord their opinions probative weight.

It is clear to the undersigned that Claimant's previous job required more than a moderate amount of physical exertion, and in fact, required that Claimant actually perform sustained exertion throughout his work shifts. Drs. Cohen and Diaz concluded that Claimant was totally disabled from performing his last coal mining job. Upon review of the opinions, I find that Drs. Cohen and Diaz's conclusions are entitled to more weight than the probative opinions by Drs. Rosenberg and Spagnolo due to the fact that Drs. Cohen and Diaz gave more credence to the actual exertional requirements of Claimant's last position.

I have determined that the opinions of Drs. Cohen and Diaz are best supported by the evidence, and thus, the most probative. Therefore, I find that Claimant has proven by a preponderance of the evidence that he is totally disabled under § 718.204(b)(2)(iv).

Claimant has not established that he is totally disabled under subsection (b)(2)(i)-(iii), but has conclusively proven total disability under subsection (b)(2)(iv). Upon weighing all evidence concerning total disability under §718.204 (b)(2), I find that the best supported narrative medical opinions, which were based on the objective test results considered in conjunction with the heavy exertional requirements of Claimant's last coal mine job, to be the most probative. Therefore, I find that Claimant has established that he is totally disabled from a pulmonary or respiratory standpoint from performing his last coal mining job.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether a miner's total disability was caused by a miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal*

Co. v. Smith, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf.* 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

The only physicians of record to find Claimant to be totally disabled from performing the exertional requirements of his last coal mining job are Drs. Knight, Cohen, and Diaz. However, I have found Dr. Knight's opinion to be less probative based on the fact that he focused on Claimant's ability to continue working in a dusty or dirty environment, and failed to identify Claimant's pulmonary capacity to perform the physical labor required by his last position. I also accord the opinions of Drs. Cohen and Diaz more weight than the contrary opinions because they diagnosed total disability due, in part, to pneumoconiosis, while Drs. Rosenberg and Spagnolo failed to even diagnosis the existence of pneumoconiosis. The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and found that the Miner was totally disabled are more reliable for assessing the etiology of Miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

I have found that the opinions by Drs. Cohen and Diaz are the most probative as to whether Claimant's total disability was the result of his pneumoconiosis. Therefore, upon weighting all of the opinions of record, I find that the preponderance of the evidence supports a finding of total disability due to pneumoconiosis.

Entitlement

Claimant has established the existence of pneumoconiosis arising out of coal mine employment. He has also proven, by a preponderance of the evidence, that he is totally disabled due to pneumoconiosis. Therefore, I find that Claimant is entitled to benefits under the Act. However, as I cannot determine the month of onset of total disability due to pneumoconiosis, I find that benefits are payable to Claimant beginning with the month in which he filed his application for benefits. *See* § 725.503(b). Therefore, since he filed his application for benefits in August 2004, I find that benefits are payable beginning with that month.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties,

including Claimant. The parties have 10 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

ORDER

IT IS ORDERED that the claim of M.D.A. for benefits under the Act is hereby GRANTED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).